TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01540

CERTIFICATE OF DEATH

01537

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest tawn): CUMBERLAND
c. LENGTH OF STAY IN 1b: 33 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: W. VIRGINIA
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn): WILEY FORD
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARVEY — Middle E. — Lost ABE

4. DATE OF DEATH: Month FEB. — Doy 19, — Year 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12-3-89

9. AGE (In yeors last birthday): 77 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (County & State, or foreign country): WEST VIRGINIA-LEVELS

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JOHN ABE

14. MOTHER'S MAIDEN NAME: MARTHA MORELAND

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MEMORIAL HOSPITAL- Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Dehydration and electrolyte imbalance — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO
(b): Carcinoma of prostate and colon, with bony and pulmonary metastases — 2 years
DUE TO
(c):
Conditions, if any, which gave rise to immediate couse (o), stating the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Diabetes mellitus, very mild

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor: Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Dec. 17th, 19 66, to Feb. 19, 19 67, that (I) (we) last saw the deceased alive on Feb. 19, 19 67, and that death occurred at 10:15 P. M. from causes and on the date stated above.

22a. SIGNATURE: Wyand F. Doerner Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-22-67

22c. PHYSICIAN'S NAME (Type): DR. WYAND F. DOERNER Jr.

22d. ADDRESS: 414 N. MECHANIC ST., CUMBERLAND, MD

23o. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Feb.22,1967

23c. NAME OF CEMETERY OR CREMATORY: ABE CEMETERY

23d. LOCATION (City or Town) (County) (State): WILEY FORD, WEST, VIRGINIA

24. FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli, Cumberland, Md.

25o. REC'D BY REGISTRAR DATE: FEB 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01541

CERTIFICATE OF DEATH

01538

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/66

1. PLACE OF DEATH
   a. COUNTY: Allegany
   b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Cumberland
   c. LENGTH OF STAY IN 1b: 2 months
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Sylvan Retreat

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Allegany
   c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Rt. #6, Cumberland
   d. STREET ADDRESS: McMullen Highway
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Samuel; Middle: Singleton; Lost: Adams

4. DATE OF DEATH: Month: Feb.; Doy: 10; Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/29/94

9. AGE (In yeors last birthday): 72 yrs.

IF UNDER 1 YEAR: Months; Doys. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (County & Stote, or foreign country): Buffalo Mills, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Silas Adams

14. MOTHER'S MAIDEN NAME: Cora Suter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No

16. SOCIAL SECURITY NO.: 161-12-6641

17. INFORMANT Address: Mrs. Maude Adams, Cumberland, Md. RD6

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Effusion of Brain
DUE TO (b): Residuals of Left Hemiplegia left
DUE TO (c): 17-11 Senile - Psychosis
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
5810

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 21, 1966, to Feb. 10, 1967, that (I) (we) last saw the deceased alive on Feb. 9 1967, and that death occurred at 6:30 AM, from causes and on the date stated above.

22a. SIGNATURE: L. B. Mathews M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): L. B. Mathews, M.D.

22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 13, 1967

23c. NAME OF CEMETERY OR CREMATORY: Dry Ridge Cemetery

23d. LOCATION (City or Town) (County) (State): Manns Choice, Pa. RD#1

24. FUNERAL DIRECTOR: Howard N. Flegler ADDRESS: Hyndman, Pa.

25a. REC'D BY REGISTRAR DATE: FEB 16 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01542 — 01539

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 5 Minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
d. STREET ADDRESS: Railroad Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle Last ANDERSON
4. DATE OF DEATH: Month 2/8/1967 Day Year 19
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/29/1905
9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Celanese Employee
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lonaconing, MD.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William Anderson
14. MOTHER'S MAIDEN NAME: Minerva Miller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: MRS. ETHEL ANDERSON, Lonaconing, MD. (WIFE)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Occlusion	Minutes
DUE TO (b)	Coronary Thrombosis	---
DUE TO (c)	Coronary Sclerosis	---

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: February 8, 1967
Address (Street, city, town, or county): Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/10/1967
22c. NAME OF CEMETERY OR CREMATORY: Memorial Park
22d. LOCATION (City, town, or country) (State): Frostburg, MD.

23. FUNERAL DIRECTOR: George Eichhorn
ADDRESS: Lonaconing, MD.
24a. REC'D BY REGISTRAR DATE: FEB 9 1967
24b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01543

CERTIFICATE OF DEATH

01540

1. PLACE OF DEATH
a. COUNTY: ALLEGANY CO. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND 01-1
d. STREET ADDRESS: 313 MARYLAND AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

50

3. NAME OF DECEASED (Type or print): First JAY — Middle ALLEN — Last BATES

4. DATE OF DEATH: Month FEB — Day 17 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-12-67

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months — Days 5 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -----

10b. KIND OF BUSINESS OR INDUSTRY: -----

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN H BATES, JR

14. MOTHER'S MAIDEN NAME: JOYCE R ~~WOOD~~ GOODMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ***

(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: -----

17. INFORMANT Address: MEMORIAL HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Prematurity (5 mos gestation) — 5 Days
DUE TO (c):

7635

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Infantile type Coarctation of Aorta, Hyaline Membrane.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 12, 1967 to Feb 17, 1967, that (I) (we) last saw the deceased alive on Feb 17, 1967, and that death occurred at 6:50 AM, from causes and on the date stated above.

22a. SIGNATURE: R. A. Reiter — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/20/67

22c. PHYSICIAN'S NAME (Type): DR. R. A. REITER

22d. ADDRESS: 112 Bedford St 461 DECATUR ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb 20, 1967

23c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park

23d. LOCATION (City or Town) (County) (State): Frostburg, Allegany Md.

24. FUNERAL DIRECTOR: John J. Hafer, Jr.

ADDRESS: 230 Baltimore Ave. Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: FEB 23 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

7-215-473

VR A15 (4) 20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01544 01541

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 402 Pulaski St.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Alleganey
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 402 Pulaski St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Margaret Middle: A. Last: Blake

4. DATE OF DEATH: Month: Feb. Day: 16 Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Feb. 28, 1876

9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): Corriganville, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Augustine Burkey

14. MOTHER'S MAIDEN NAME: Rose Mattingly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: None.

17. INFORMANT: Edward Blake Address: Comberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Uraemia	2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerosis	10 yrs
DUE TO (c)	Myocarditis	5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 1, 1967, to Feb. 17, 1967, that (I) (we) last saw the deceased alive on Feb. 10, 1967, and that death occurred at ____M, from the causes and on the date stated above.

22a. SIGNATURE: Clark E. Jones M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/17/67

22c. PHYSICIAN'S NAME (Type): /

22d. ADDRESS: 236 Va Ave Cumberland Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/20/67

23c. NAME OF CEMETERY OR CREMATORY: St. Patricks Cem.

23d. LOCATION (City, town or county) (State): Mt. Savage Md

24. FUNERAL DIRECTOR: Louis Stein Inc. ADDRESS: Cumb. Md.

25a. REC'D BY REGISTRAR DATE: FEB 20 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 21, give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01545 01542

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 69 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): 404 Pennsylvania Avenue

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 404 Pennsylvania Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: B. — Last: Brant

4. DATE OF DEATH: Month: Feb. — Day: 19 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 28, 1898

9. AGE (In years last birthday): 68-68 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas W. Brant

14. MOTHER'S MAIDEN NAME: Daisy Valentine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Daughter
Address: Mrs. Robert M. Tabler, Ravenna, Ohio

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion, Left — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Coronary Thrombosis, Left — --
DUE TO (c): Coronary Sclerosis — --
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: February 19, 1967

Address (Street, city, town, or county): Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 22, 1967

23c. NAME OF CEMETERY OR CREMATORY: Zion Memorial Park

23d. LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR: James F. Scagetti — ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: FEB 23 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01546

CERTIFICATE OF DEATH

01543

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 3 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND 01-1
d. STREET ADDRESS: R.T.# 1 BOX 582
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELVA Middle C. Last BROTEMARKLE

4. DATE OF DEATH: Month FEB. Day 21 Year 19 67

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-22-00
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Clergyman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): LUKE, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lloyd Weller
14. MOTHER'S MAIDEN NAME: Rhoda Shoemaker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 216-22-6144
17. INFORMANT: PT'S CHART Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Irreversible Shock — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.
DUE TO (b): Myocardial Infarction — 30 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/1, 1967, to 2/21, 1967, that (I) (we) last saw the deceased alive on 2/21 1967, and that death occurred at 5:15 PM, from the causes and on the date stated above.

22a. SIGNATURE: John Pagan M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/22/67
22c. PHYSICIAN'S NAME (Type): DR. PAGAN, M.D.
22d. ADDRESS: Ridgeley W. Va

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/24/67
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
23d. LOCATION (City, town or county) (State): Cumberland Allegany Md

24. FUNERAL DIRECTOR: H. Lee Silcox
ADDRESS: Cumberland Maryland 21502
25a. REC'D BY REGISTRAR DATE: FEB 23 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01547

CERTIFICATE OF DEATH

01544

1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial, Cumberland, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE W Va b. COUNTY Mineral
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keyser 85-3
d. STREET ADDRESS 115 W Piedmont St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Anna Middle Frances Last Burk
4. DATE OF DEATH Month February Day 19 Year 1967
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4-18-1875
9. AGE (In years last birthday) 91 yrs.
IF UNDER 1 YEAR: Months 10 Days 11
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (County & State, or foreign country) Deer Park Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Richard G. Burk
14. MOTHER'S MAIDEN NAME Mary M. Whetsell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes give war or dates of service) no
16. SOCIAL SECURITY NO. 213-18-2944
17. INFORMANT Address Mrs Arvel Jeffery, Cumb. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerosis with
DUE TO (b) Coronary sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
Acute bronchitis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 2-18, 1967 to 2-19, 1967, that (I) ~~(we)~~ last saw the deceased alive on 2-18 1967, and that death occurred at 12:10 P.M., from causes and on the date stated above.

22a. SIGNATURE Howard L. Tolson M.D.
ATTENDING PHYS. ☒ M.D. MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 2-19-1967
22c. PHYSICIAN'S NAME (Type) Howard L. Tolson
22d. ADDRESS Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 2-22-67
23c. NAME OF CEMETERY OR CREMATORY Rose Hill
23d. LOCATION (City or Town) (County) (State) Elk Garden Mineral W Va

24. FUNERAL DIRECTOR Thomas Smith & Son Keyser W Va
ADDRESS
25a. REC'D BY REGISTRAR DATE FEB 21 1967
25b. REGISTRAR'S SIGNATURE J. Charles Junga

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01548

CERTIFICATE OF DEATH

01545

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
o. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Cumberland
c. LENGTH OF STAY IN 1b: 6/29/1955
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
o. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Corriganville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Catherine — Middle J. — Lost Corrigan
4. DATE OF DEATH: Month February — Doy 16, — Year 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/9/1869
9. AGE (In yeors last birthdoy): 97 yrs.
IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & Stote, or foreign country): Corriganville, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Matthew Corrigan
14. MOTHER'S MAIDEN NAME: Ann Garvy
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: P.O.Box 599, Cumberland, Md. Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): (1) Hypertensive Arteriosclerotic Senile
DUE TO (b): (2) Cardio Vascular Renal Disease
DUE TO (c): (3) Arterio Sclerosis General & Cerebral
442X
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/29/ 19 55, to 2/16/ 19 67, that (I) (we) last saw the deceased alive an 2/15/ 19 67, and that death accurred at A. M, from causes and an the date stated above.

22a. SIGNATURE: L Mathews M.D. — at 2:25 A. M. — ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒
22b. DATE SIGNED: 2/16/1967
22c. PHYSICIAN'S NAME (Type): Lee B. Mathews, M. D.
22d. ADDRESS: 49 Greene St., Cumberland, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/20/67
23c. NAME OF CEMETERY OR CREMATORY: St. Patricks Cem.
23d. LOCATION (City or Town) (County) (State): Cumberland Md
24. FUNERAL DIRECTOR: Laura Stein Inc. — ADDRESS: Cumb. Md.
25o. REC'D BY REGISTRAR DATE: FEB 20 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01549 — 01546

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1 Year
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 32½ West 1st Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 32½ W. 1st St.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: S. — Last: Cox

4. DATE OF DEATH: Month: February — Day: 8, — Year: 1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	April 25, 1897	69 yrs.	9 / 13	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Dective		Atlanta, Georgia	USA

13. FATHER'S NAME: George W. Cox
14. MOTHER'S MAIDEN NAME: Florence Perry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes	W.W. #1	265-01-7388	Mrs Inez Bohrer Cox, Cumberland, Md.	32½ W. 1st. St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Acute

DUE TO (b): Arteriosclerosis — 2 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

3

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct. 15 1966 to Feb. 8, 1967 that (I) (we) last saw the deceased alive on Dec. 10 1966, and that death occured at 1152 M, from the causes and on the date stated above.

22a. SIGNATURE: Clay E. Durrett M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2/11/67

22c. PHYSICIAN'S NAME (Type): Clay E. Durrett, MD — 22d. ADDRESS: 236 Va. Ave. Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	2/10/1967	Woodrow Cem.	Paw Paw, West Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: E. E. Johnson — ADDRESS: Johnson Funeral Homes, Berkeley Spgs. W. Va. — 25a. REC'D BY REGISTRAR DATE: FEB 14 1967 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01550

01547

FOR STATE HEALTH DEPT. 1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 62 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): D. O. A. Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside carporate limits, write RURAL and give neorest town): Cumberland
d. STREET ADDRESS: 456 Baltimore Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leroy — Middle: Franklin — Lost: Crawford

4. DATE OF DEATH: Month: Feb. — Doy: 3 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 10,1905

9. AGE (In yeors last birthday): 61 yrs.

IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Roofer

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (Stote or foreign country): Cumberland, Md.

12 CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: David Crawford

14. MOTHER'S MAIDEN NAME: Mary Albright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes give wor or dotes of service): War I

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Sister
Mrs. Helen Mc Kinley, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO
(b): Myxoma of Left Auricle — ---
DUE TO
(c):

Conditions, if ony, which gave rise to immediate couse (o), stoting the underlying couse last.

2271

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES XX NO ☐

20o. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. **I certify** thot I took chorge of the remoins described obove, held on Autopsy ☒, Inspectian ☒, Inquiry ☒, ond in my opinian deoth resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Cumberland, Md.

22. DATE SIGNED: February 3, 1967

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb.6,1967

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION (City or Town) (County) (Stote): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli, Cumberland, Md.

25o. REC'D BY REGISTRAR — DATE: FEB 7 1967

25b. REGISTRAR'S SIGNATURE

VR A15ME (5)
6M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01551

CERTIFICATE OF DEATH

01548

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside carporate limits, write RURAL and give neorest town): Frostburg
c. LENGTH OF STAY IN 1b: 4 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest tawn): Mt Savage Box 221
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First David — Middle — Last Crump

4. DATE OF DEATH: Month February — Day 23 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 20, 1890

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Employee- Kelly S. Tire Company

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Allegany Co Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Crump

14. MOTHER'S MAIDEN NAME: Margaret Brode

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 214-05-9823

17. INFORMANT: Mrs. Belva Crump — Address: Box 221 Mt Savage, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 11 hrs
DUE TO
Conditians, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Cardiovascular Disease — 10 yrs
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Tuberculosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): X

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): X

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.: X 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): X

20f. (City or town) (County) (State): X

21. I **certify** that (I) (this hospital) attended the deceased from 2/18, 19 67, to 2/23, 19 67, that (I) (we) last saw the deceased alive on 2/23 19 67, and that death occurred at 1.45 A M, from causes and on the date stated above.

22a. SIGNATURE: Martin M. Rothstein M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/24/67

22c. PHYSICIAN'S NAME (Type): MARTIN M. ROTHSTEIN M.D.

22d. ADDRESS: 48 BROADWAY - FROSTBURG - MD. 21532

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/25/67

23c. NAME OF CEMETERY OR CREMATORY: Mt Savage Methodist Cem

23d. LOCATION (City or Town) (County) (State): Mt Savage Allegany Maryland

24. FUNERAL DIRECTOR: H. Lee Silcox — ADDRESS: Cumberland Maryland 21502

25a. REC'D BY REGISTRAR DATE: FEB 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01552 — 01549

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 HRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town): BOWLING GREEN, CUMBERLAND
d. STREET ADDRESS: CRESAP 140 ~~CRESAP~~ DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy A — Lost: CURRENCE
4. DATE OF DEATH: Month: FEBRUARY — Doy: 7 — Year: 19 67
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-7-67
9. AGE (In yeors lost birthday): 2 HRS.
IF UNDER 1 YEAR: Months: OLD — Doys — IF UNDER 24 HRS.: Hours — Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: WILLIAM W. CURRENCE
14. MOTHER'S MAIDEN NAME: ROBINETTE, JANET M.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): 776X — Prem Birth
DUE TO
(b):
DUE TO
(c):
Conditions, if ony, which gave rise to immediote couse (o), stoting the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): 2nd Twin Fetal
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) ottended the deceosed from _____, 19__, to 6:40 P.M., 19__, thot (I) (we) last saw the deceased olive on _____ 19__, and that deoth occurred at _____M, from causes ond on the dote stoted above.

22o. SIGNATURE: Delbert M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2-8-67
22c. PHYSICIAN'S NAME (Type): DR. AMERICO T. VALDES
22d. ADDRESS: CUMBERLAND, MD.

23o. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 2-10-67
23c. NAME OF CEMETERY OR CREMATORY: Memorial Hospital
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Maryland

24. FUNERAL DIRECTOR — ADDRESS: John A. Mohler — 7-296-446
25o. REC'D BY REGISTRAR — DATE: FEB 15 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01553

CERTIFICATE OF DEATH

01550

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Allegany
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 3 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Sylvan Retreat

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 18 W. First Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Inez; Middle: ; Last: Dawson

4. DATE OF DEATH: Month: Feb. Day: 20 Year: 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4/22/72
9. AGE (In years last birthday): 94 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Registered Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Self Employed
11. BIRTHPLACE (County & State, or foreign country): Grafton, W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: A. H. (Art) Kelly
14. MOTHER'S MAIDEN NAME: Susan Keister

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Nina Straser, New Carrollton, Md. Address: Granddaughter

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): (1) Myocardial Ins. degeneration Senile
DUE TO: (2) Arteria sclerosis general & cerebral
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: (3) Headaches "Little Strokes"
(c) (4) 17:11 Senile Psychosis

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify thot (I) (this hospitol) ottended the deceased from Nov. 25, 19 66, to Feb. 20, 19 67, thot (I) (we) lost sow the deceased olive on Feb. 19 19 67, and thot deoth occurred ot 1 A M, from couses ond on the dote stoted obove.

22a. SIGNATURE: L. B. Mathews M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): L. B. Mathews, M.D.
22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb.22,1967
23c. NAME OF CEMETERY OR CREMATORY: Rockwood Cemetery
23d. LOCATION (City or Town) (County) (State): Rockwood, Pa.

24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md. ADDRESS
25a. REC'D BY REGISTRAR DATE: FEB 23 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01554 — 01551

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/66

1. PLACE OF DEATH a. COUNTY: ALLEGANY — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND — b. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn): CUMBERLAND c. LENGTH OF STAY IN 1b: 3 DAYS	c. CITY OR TOWN (If outside carparate limits, write RURAL and give neorest town): CUMBERLAND
d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address): MEMORIAL HOSPITAL	d. STREET ADDRESS: 1109 VIRGINIA AVE. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: ROBERT	Middle: L.	Last: DEATELHAUSER	4. DATE OF DEATH	Month: FEBRUARY	Day: 20	Year: 1967	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 8-25-1888	9. AGE (In years last birthday): 78 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired	10b. KIND OF BUSINESS OR INDUSTRY: Municipal	11. BIRTHPLACE (County & Stote, or foreign country): MARYLAND-CUMBERLAND	12. CITIZEN OF WHAT COUNTRY?: U. S. A.					
13. FATHER'S NAME: JOSEPH DEATELHAUSER	14. MOTHER'S MAIDEN NAME: JENNIE VALENTINE							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown): no (If yes give war or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: MEMORIAL HOSPITAL, MEMORIAL AVE. (Address)						

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Anemia	Unknown
DUE TO (b)	Nephrosclerosis	Months
DUE TO (c)	Arteriosclerosis	Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — 446X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II af item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at wark ☐ Nat While at wark ☐	20e. PLACE OF INJURY (Hame, farm, factary, street, affice bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/16, 1967 to 11:10 PM 2/19, 1967, that (I) (we) last saw the deceased alive an 2/19 1967, and that death accurred at ____ M, from causes and an the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED: 2/20/67
22c. PHYSICIAN'S NAME (Type): DR. S. G. WEISMAN	22d. ADDRESS: CUMBERLAND, MD.	

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: Feb.22,1967	23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Park	23d. LOCATION (City or Town) (County) (State): Cumberland,Md.Allegany
24. FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli, Cumberland,Md.	25a. REC'D BY REGISTRAR DATE: FEB 24 1967	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01555

CERTIFICATE OF DEATH

01552

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
c. LENGTH OF STAY IN 1b: 2 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Kyle Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
d. STREET ADDRESS: 102 Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Oscar — Last: Droege

4. DATE OF DEATH: Month: Feb. — Day: 4 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan 3, 1886

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Rail Road

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Oscar [illegible] Droege

14. MOTHER'S MAIDEN NAME: Rosa Rust

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 705 05 5289

17. INFORMANT: Otto Droege — Address: Cumberland, Md.

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Ischemia
DUE TO
(b): Arteriosclerosis
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from _____, 1966, to 2-4, 1967, that (I) (we) last saw the deceased alive on Jan 30 1967, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: [signature] — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-6-67

22c. PHYSICIAN'S NAME (Type): Leslie R. Miles

22d. ADDRESS: Lonaconing, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/7/67

23c. NAME OF CEMETERY OR CREMATORY: Oakland, Cem.

23d. LOCATION (City or Town) (County) (State): Oakland Garrett Md.

24. FUNERAL DIRECTOR: [signature]

ADDRESS: Westernport, Md.

25a. REC'D BY REGISTRAR DATE: FEB 9 1967

25b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G385 2/17/67 pc

01556

CERTIFICATE OF DEATH

01553

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 32 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CUMBERLAND MEMORIAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): BARTON
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KATHLEEN Middle Last DYE

4. DATE OF DEATH: Month FEBRUARY Day 5 Year 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-24-1917
9. AGE (In years last birthday): 50 / 49 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): BARTON, MD.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: ELLIS JAMES DYE
14. MOTHER'S MAIDEN NAME: ELLA FOUTZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give wor or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: MEMORIAL HOSPITAL, CUMB. MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Pulmonary Metastese — INTERVAL BETWEEN ONSET AND DEATH: 2-3 yrs
DUE TO
(b): Carcinoma of breast
DUE TO
(c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
170X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I ar Port II af item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, affice bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 67, 19__ to Feb 67, 19__, that (I) (we) last saw the deceased alive on 2/5 1967, and that death occurred at 2:55 AM, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/9/67
22c. PHYSICIAN'S NAME (Type): DR. S. G. WEISMAN
22d. ADDRESS: 59 GREENE ST.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/8/67
23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill
23d. LOCATION (City or Town) (County) (State): Moscow Mills Md.

24. FUNERAL DIRECTOR: [signature]
ADDRESS: Westernport, Md.
25a. REC'D BY REGISTRAR DATE: FEB 10 1967
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01557

CERTIFICATE OF DEATH

01554

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): McCoole rural
c. LENGTH OF STAY IN 1b: 10 Yrs
d. NAME OF HDSPITAL OR INSTITUTION (If not in hospital, give street address): R.D. 1Westernport

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Allegany
c. CITY OR TOWN (If outside carporote limits, write RURAL and give nearest town): McCoole -rural
d. STREET ADDRESS: R.D. 1 Westernport
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Kenneth — Middle: Clark — Last: Fisher

4. DATE OF DEATH: Month: Feb. — Day: 21 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 24, 1914
9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Research
10b. KIND OF BUSINESS OR INDUSTRY: Paper Mill
11. BIRTHPLACE (County & State, or foreign country): Allegany, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edwin Fisher
14. MOTHER'S MAIDEN NAME: Edith Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 217-05-0421
17. INFORMANT: Madeline Fisher — Address: R.D. 1, Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b): ASCVD — 15 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arthritis, Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1955, 19___, to 2-21-67, 19___, that (I) (we) last saw the deceased alive on 2-20-67, 19___, and that death occurred at 7:30 A M, from causes and on the date stated above.

22a. SIGNATURE: William W Lesh — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2-21-67
22c. PHYSICIAN'S NAME (Type): William W. Lesh
22d. ADDRESS: Westernport, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/24/67
23c. NAME OF CEMETERY OR CREMATORY: St. Peters
23d. LOCATION (City or Town) (County) (State): Westernport Md.

24. FUNERAL DIRECTOR: E. P. Bond
ADDRESS: Westernport, Md.
25a. REC'D BY REGISTRAR DATE: FEB 23 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)
25M 1/67

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01558

01555

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: ROUTE 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ROBERT	NEEL	FLORA	FEB.	17	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE		SEPT. 4,1917	49 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MILL ROOM WORKER	TIRE INDUSTRY	MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ELLIS FLORA	EDITH FLORA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
YES	WW 2	214 07 4927	MARGARET FLORA, ROUTE 2, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	CEREBRAL HEMORRHAGE	4 days
DUE TO	443X	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	HYPERTENSIVE CARDIOVASCULAR DISEASE	----
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 2/18/67

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D. RT. 9, CUMBERLAND, MD. (Address, town, county)

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
BURIAL	FEB. 20,1967	ZION MEMORIAL PARK	CUMBERLAND, MD.

23. FUNERAL DIRECTOR	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
BYRON KIGHT	CUMBERLAND, MD.	FEB 21 1967	J. Charles Index

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01559 01556

1. PLACE OF DEATH
a. COUNTY: ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 239 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND,
d. STREET ADDRESS: 16½ PENNSYLVANIA AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First VIRGINIA Middle ELIZABETH Last FORBECK
4. DATE OF DEATH: Month FEBRUARY Day 11 Year 19 67
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5-22-1899
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleslady
10b. KIND OF BUSINESS OR INDUSTRY: Women's Apparel
11. BIRTHPLACE (County & State, or foreign country): MARYLAND, Cumberland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: JACOB BURNS
14. MOTHER'S MAIDEN NAME: MARY GA[illegible]ER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No,
16. SOCIAL SECURITY NO.: 172-07-9386D
17. INFORMANT Address: MEMORIAL HOSPITAL-CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Primary Aplastic Anemia — INTERVAL BETWEEN ONSET AND DEATH: 2 12 yrs
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
2924

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1964, 19 to 2-11, 1967, that (I) (we) last saw the deceased alive on 2-11 1967, and that death occurred at 5:15 A.M., from causes and on the date stated above.

22a. SIGNATURE: William R James M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/14/67
22c. PHYSICIAN'S NAME (Type): DR. W. P. JAMES
22d. ADDRESS: 441 N. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/14/67
23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cemetery
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR: H. Wayne George
ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: FEB 17 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01560

CERTIFICATE OF DEATH

01557

1. PLACE OF DEATH
a. COUNTY: Allegany
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 7/16/63
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 312 Spruce St. Westernport, Maryland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Florence; Middle: ; Last: Foster

4. DATE OF DEATH: Month: 2; Day: 14; Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/17 / 1883

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Lonaconing, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mr. George Ternent

14. MOTHER'S MAIDEN NAME: Mary Crowe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: P.O. Box 599 Cumb.,Md.
Allegany County Infirmary Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) (1) Myocarditis, Chr degenerative
DUE TO (2) Arterio Sclerosis & Hypostatic Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO (3) Chr Pyelonephritis
(c) (4) Chr Cholecystitis

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 7/16/1963, 19___, to 2/14/1967, 19___, that (I) (we) last saw the deceased alive on 2/14/1967, 19___, and that death occurred at 2:00 P.M., from causes and on the date stated above.

22a. SIGNATURE: W Mathews M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒

22b. DATE SIGNED: 2/15/1967

22c. PHYSICIAN'S NAME (Type): Lee B. Mathews, M.D.

22d. ADDRESS: 49 Greene St. Cumb., Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/17/67

23c. NAME OF CEMETERY OR CREMATORY: PHILOS CEM.

23d. LOCATION (City or Town) (County) (State): WESTERNPORT Md.

24. FUNERAL DIRECTOR: E J Bowl
ADDRESS: Westernport, Md

25a. REC'D BY REGISTRAR DATE: FEB 17 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01561 01558

1. PLACE OF DEATH
a. COUNTY ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
c. LENGTH OF STAY IN 1b 10 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRESAPTOWN
d. STREET ADDRESS 205 McMullen Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First EUGENE Middle KERMIT Last FURLOW
4. DATE OF DEATH Month FEBRUARY Day 12 Year 1967
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 7-18-1908
9. AGE (In years last birthday) 58 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTOMOBILE MECHANIC
10b. KIND OF BUSINESS OR INDUSTRY GARAGE LIGHT & DECKER
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME FURLOW, THOMAS
14. MOTHER'S MAIDEN NAME ELIZABETH HULL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 186-01-7895
17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis - Colon, Lung, Kidney
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/4/67 to 2/11/67, that (I) (we) last saw the deceased alive on 2/11 1967 and that death occurred at 3:25 A.M., from causes and on the date stated above.

22a. SIGNATURE Thomas F. Lusby M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 2/13/67
22c. PHYSICIAN'S NAME (Type) DR. THOMAS F. LUSBY
22d. ADDRESS 932 NATIONAL HIGHWAY, LA VALE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 2/15/67
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR H. Wayne George
ADDRESS Cumberland, Md.
25a. REC'D BY REGISTRAR DATE FEB 17 1967
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01562

CERTIFICATE OF DEATH

01559

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN 1b: 7 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Miner's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Frostburg (Rural)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Rose — Middle: EDITH — Last: GARLITZ

4. DATE OF DEATH: Month: Feb. — Doy: 10 — Year: 1967

5. SEX: F — 6. COLOR OR RACE: W — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: Oct. 15, 1880 — 9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & Stote, or foreign country): Finzel, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Urias McKenzie
14. MOTHER'S MAIDEN NAME: Cordellia Hutzell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.: ---
17. INFORMANT — Address: Thomas McKenzie, R.D. Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 25 yrs?
DUE TO
(b):
DUE TO
(c):
Conditions, if ony, which gave rise to immediate couse (o), stoting the underlying couse last.
422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) X
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor / Hour o.m. p.m. / 19 X
20d. INJURY OCCURRED While at work ☐ Not While at work ☐ X
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) X
20f. (City or town) (County) (Stote) X

21. I certify that (I) (this hospital) attended the deceased from 2 Feb. , 1967, to 10 Feb , 1967, that (I) (we) last saw the deceased alive on 10 Feb 1967, and that death occurred at 2:40 P.M, from causes and on the date stated above.

22a. SIGNATURE: Martin M. Rothstein M.D.
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/12/67
22c. PHYSICIAN'S NAME (Type): MARTIN M. ROTHSTEIN M.D.
22d. ADDRESS: 48 BROADWAY - FROSTBURG - MD. 21532

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb. 13, 1967
23c. NAME OF CEMETERY OR CREMATORY: St. Michaels Cem.
23d. LOCATION (City or Town) (County) (Stote): Frostburg, Allegany, Md.

24. FUNERAL DIRECTOR: Von Freeman — ADDRESS: Grantsville, Md.
25a. REC'D BY REGISTRAR DATE: FEB 14 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Junge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01563

CERTIFICATE OF DEATH

01560

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): LaVALE
c. LENGTH OF STAY IN 1b: MONTHS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): JOHN'S LANE

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND 01-1
d. STREET ADDRESS: 414 OLDTOWN ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	MAGDALENA	MINNIE	GREEN		FEBRUARY	19,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE		APRIL 24, 1882	84 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWORK	DOMESTIC	ALLEGANY, MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN REUSCHEL	ANNA ~~REUSCHEL~~ HARTUNG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	220-34-1625	WM. J. CREEGAN, JOHN'S LANE, LaVALE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmo-vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year

442X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) osteosclerosis — 6 years
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-2-, 1960, to 2-19-, 1967, that (I) (we) last saw the deceased alive on 2-18- 1967, and that death occurred at 3 AM, from the causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
L. Brings		2-20-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
L. Brings	57 Greene St., Cumberland, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
BURIAL	FEB. 21, 1967	TRINITY LUTHERAN CEMETERY	CUMBERLAND, ALLEGANY, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOHN J. HAFER, JR., 230 BALTO. AVE., CUMB., MD.	FEB 23 1967	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01564 01561

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAVALE MD
d. STREET ADDRESS: 17 GLEN VIEW TERRACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ALBERT Middle D. Last HEACOX
4. DATE OF DEATH: Month FEBRUARY Day 7 Year 19 67
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-18-01
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoe Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Shoe Store (Self)
11. BIRTHPLACE (County & State, or foreign country): ALTOONA, PA.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: HEACOX, ROBERT
14. MOTHER'S MAIDEN NAME: DICK, JEANETTA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW I
16. SOCIAL SECURITY NO.
17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 7 Hrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/5/67, 19 8:40 P.M., 19__, that (I) (we) last saw the deceased alive on 2/7/67 19__, and that death occurred at __ M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/9/67
22c. PHYSICIAN'S NAME (Type): DR. RICHARD WILLIAMS
22d. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/10/67
23c. NAME OF CEMETERY OR CREMATORY: Rosedawn Memo. Pk.
23d. LOCATION (City or Town) (County) (State): Cumberland MD

24. FUNERAL DIRECTOR: Davis Stein Inc. ADDRESS: Cumb. MD
25a. REC'D BY REGISTRAR DATE: FEB 14 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01565

CERTIFICATE OF DEATH

01562

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 HR. 20 MIN.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 353 BALTIMORE AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MINNIE Middle O Last HICKLE

4. DATE OF DEATH: Month FEBRUARY Day 18 Year 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-11-81

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JOHN W. JONES

14. MOTHER'S MAIDEN NAME: MARY E. (UNKNOWN)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 214 05 8522

17. INFORMANT: MEMORIAL HOSPITAL, Address CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: HOURS
DUE TO
(b): Arteriosclerotic Cardiovascular Disease — years
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept, 19 [illegible] to Feb, 19 67, that (I) (we) last saw the deceased alive on 2/18/67, 19 [illegible], and that death occurred at 10:30 P.M. from causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/19/67

22c. PHYSICIAN'S NAME (Type): DR. G. OVERTON HIMMELWRIGHT
22d. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: FEB. 22, 1967
23c. NAME OF CEMETERY OR CREMATORY: HILLCREST BURIAL PARK
23d. LOCATION (City or Town) (County) (State): CUMBERLAND, MD.

24. FUNERAL DIRECTOR: BYRON KIGHT
ADDRESS: CUMBERLAND, MD.

25a. REC'D BY REGISTRAR DATE: FEB 27 1967
25b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01566

CERTIFICATE OF DEATH

01563

1. PLACE OF DEATH
a. COUNTY ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) CUMBERLAND
c. LENGTH OF STAY IN 1b 78 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.
d. STREET ADDRESS 227 ARCH ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First LUCY Middle ANN Last HUMBERTSON
4. DATE OF DEATH Month FEB. Day 7 Year 19 67
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH March 25, 1881
9. AGE (In years last birthday) 85 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (County & State, or foreign country) ~~WEST VIRGINIA~~ Cleveland Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME AD SIRBAUGH -ALVEY SIRBAUGH
14. MOTHER'S MAIDEN NAME SARAH LEDWICK
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uraemia — INTERVAL BETWEEN ONSET AND DEATH 4 hrs
DUE TO (b) R. Cerebral Haemorrhage — 2 mon
DUE TO (c) Left Hemiplegia — 2 mon
331X
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 1966 to Feb 7, 1967, that (I) (we) last saw the deceased alive on Feb. 7 1967, and that death occurred at 11:05A.M. from causes and on the date stated above.

22a. SIGNATURE Clay R. Durrett M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 2/8/67
22c. PHYSICIAN'S NAME (Type) DR. CLAY DURRETT
22d. ADDRESS 236 VA. AVENUE, CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF Feb.8,1967
23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Park
23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany

24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR DATE FEB 10 1967
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01567 — 01564

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Corriganville
c. LENGTH OF STAY IN 1b: 40 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Corriganville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter — Middle: J. — Last: Jensen

4. DATE OF DEATH: Month: February — Day: 3, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 20, 1890

9. AGE (In years last birthday): 76 (76) yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): B&O Shops

10b. KIND OF BUSINESS OR INDUSTRY: Railroading

11. BIRTHPLACE (State or foreign country): ~~Denmark~~ Coleman, Wis.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: unkn

14. MOTHER'S MAIDEN NAME: unkn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1914-1928 Navy

16. SOCIAL SECURITY NO.: 705-05-4750

17. INFORMANT — Address: Harry Stegmaier, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b): Coronary sclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

DATE SIGNED: Feb. 4, 1967

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 5, 1967

22c. NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery

22d. LOCATION (City, town, or county) (State): Hyndman, Pennsylvania

23. FUNERAL DIRECTOR: Harvey D. Zeigler — ADDRESS: Hyndman, Pennsylvania

24a. REC'D BY REGISTRAR DATE: FEB 9 1967

24b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01568

CERTIFICATE OF DEATH

01565

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 44 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: PA. — b. COUNTY: BEDFORD
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYNDMAN, PA. RT. 1
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: GUY — Middle: F — Last: KENNELL

4. **DATE OF DEATH**: Month: FEB — Day: 20 — Year: 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 9-19-89

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (County & State, or foreign country): PENNA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM B. KENNELL

14. MOTHER'S MAIDEN NAME: EFFIE LEPLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-34-1285

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 45 days
DUE TO
(b): generalized arteriosclerosis
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1958, 19__, to 1-20, 1967, that (I) (we) last saw the deceased alive on 1-20 1967, and that death occurred at 1:30 PM, from causes and on the date stated above.

22a. SIGNATURE: William P James M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 2/21/67

22c. PHYSICIAN'S NAME (Type): DR. WILLIAM P. JAMES

22d. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 23, 1967

23c. NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery

23d. LOCATION (City or Town) (County) (State): Hyndman, Bedford Co., Pa.

24. FUNERAL DIRECTOR: Howard H. Zeigler — ADDRESS: Hyndman, PA.

25a. REC'D BY REGISTRAR DATE: FEB 28 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used os o burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removol, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01569

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01566

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): 37 MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): CUMBERLAND
d. STREET ADDRESS: 37 MEMORIAL AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First IRA Middle H. Lost KING

4. DATE OF DEATH: Month FEB. Doy 13 Year 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCT. 26,1897

9. AGE (In yeors lost birthdoy): 69 yrs.

IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STREET WORKER

10b. KIND OF BUSINESS OR INDUSTRY: CITY GOV'T

11. BIRTHPLACE (Stote or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CALVIN I. KING

14. MOTHER'S MAIDEN NAME: CORA F. PERDEW

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 217 10 6418

17. INFORMANT: MRS. LOLA E. KONG Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO
(b): CORONARY SCLEROSIS — --
DUE TO
(c):

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. I certify that I taak charge af the remoins described obove, held an Autopsy ☐, Inspectian ☒, Inquiry ☒, and in my apinian death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D. RT. 9, CUMBERLAND, MD. (Address (City, Town, or County))

22. DATE SIGNED: FEB.13,1967

23o. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: FEB.15,1967

23c. NAME OF CEMETERY OR CREMATORY: SUNSET MEMORIAL PARK

23d. LOCATION (City or Town) (County) (Stote): CUMBERLAND, MD.

24. FUNERAL DIRECTOR: BYRON KIGHT ADDRESS: CUMBERLAND, MD.

25o. REC'D BY REGISTRAR DATE: FEB 17 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01570

CERTIFICATE OF DEATH

01567

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LONACONING
c. LENGTH OF STAY IN 1b: 2 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KYLE NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS: 65 EAST MAIN STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle JACOB Last KUNKLE

4. DATE OF DEATH: Month FEBRUARY Day 28 Year 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JANUARY 21, 1880

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GLASS WORKER

10b. KIND OF BUSINESS OR INDUSTRY: GLASS

11. BIRTHPLACE (County & State, or foreign country): MONACA, PENNA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ADAM KUNKLE

14. MOTHER'S MAIDEN NAME: JOANNE TUNGET

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 217-16-4532

17. INFORMANT: STREET, FROSTBURG, MD MRS. JOHN A. WINEBRENNER, 144 WASHINGTON

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Ischemia
DUE TO (b): Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

INTERVAL BETWEEN ONSET AND DEATH: years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Senile Psychosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from _____, 19 62 to Feb. 28, 1967, that (I) (we) last saw the deceased alive on Feb. 23 1967, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: LR Miles M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-2-67

22c. PHYSICIAN'S NAME (Type): LESLIE R. MILES, M.D.

22d. ADDRESS: STATE ST., LONACONING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MARCH 3, 1967

23c. NAME OF CEMETERY OR CREMATORY: ST. MICHAEL'S CEM.

23d. LOCATION (City or Town) (County) (State): FROSTBURG, MARYLAND

24. FUNERAL DIRECTOR: MARILOU M. SOWERS

ADDRESS: HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG

25a. REC'D BY REGISTRAR DATE: MAR 7 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01571

CERTIFICATE OF DEATH

01568

1. PLACE OF DEATH
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   d. STREET ADDRESS: SYLVAN RETREAT
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
CARRIE	R.	LANCASTER	FEBUARY	2	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
FEMALE	WHITE		3-29-75	91 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JESSIE ROBINSON	ELMIRA (WILHELM) (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
	—	PT'S CHART

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Congestive heart failure	1 week
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Coronary thrombosis	1 year
DUE TO (c)	arteriosclerosis	1 year

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

3

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-31, 19 67, to 2-2, 19 67, that (I) (we) last saw the deceased alive on 2-2 19 67, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE	M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
L. Brings		2-3-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
DR. L BRINGS, MD.	57 GREENE ST. CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR ~~CREMATORY~~	23d. LOCATION (City, town or county) (State)
BURIAL	2-5-67	FROSTBURG MEMORIAL	FROSTBURG, ALLEG. MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Joseph R. Durst Sr. Frostburg, Md	FEB 8 1967	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01572

CERTIFICATE OF DEATH

01569

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1/23/1967
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): 906 Cumberland 01.1
d. STREET ADDRESS: 906 E. Oldtown Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Anna — Middle Elizabeth — Last Lapp
4. DATE OF DEATH: Month February — Day 1, — Year 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/12/1874
9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired:Shirt,Pajama Factory
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Frostburg, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Andrew A. Lapp
14. MOTHER'S MAIDEN NAME: Margaret Elizabeth Wagner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 212-01-9643
17. INFORMANT: P.O.Box 599, Cumberland, Md. Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): (1) Myocarditis, Chr. degenerative — INTERVAL BETWEEN ONSET AND DEATH
592X
DUE TO (b): (2) Arteriosclerosis, general + cerebral
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): (3) Chr. Nephritis & Morbid uremia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/23/67, 19___, to 2/1/67, 19___, that (I) (we) last saw the deceased alive on 2/1/67 19___, and that death occurred at P. M, from causes and on the date stated above. at 12:00 P.M.

22a. SIGNATURE: C Mathews M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒
22b. DATE SIGNED: 2/2/1967
22c. PHYSICIAN'S NAME (Type): Lee B. Mathews, M. D.
22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: FEB.4,1967
23c. NAME OF CEMETERY OR CREMATORY: FROSTBURG MEM. PARK
23d. LOCATION (City or Town) (County) (State): FROSTBURG, MARYLAND
24. FUNERAL DIRECTOR: MARILOU M. SOWERS
ADDRESS: HAFER FUNERAL HOME 60 W.MAIN,FROSTBURG
Marilou M Sowers
25a. REC'D BY REGISTRAR DATE: FEB 9 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

01572

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01573 01570

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
   c. LENGTH OF STAY IN 1b: D O A
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
   d. STREET ADDRESS: 28 BEALL'S LANE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SALOME — Middle — Lost LA RUE

4. DATE OF DEATH: Month FEBRUARY — Doy 12, — Year 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: DEC. 1, 1891

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months — Doys
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MACHINE OPERATOR

10b. KIND OF BUSINESS OR INDUSTRY: PAJAMA FACTORY

11. BIRTHPLACE (County & Stote, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WASHINGTON WARNER

14. MOTHER'S MAIDEN NAME: NANCY ENGLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.: 217-14-4530

17. INFORMANT — Address: PAUL LA RUE, FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): ACUTE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): CORONARY ARTERY DISEASE — ½ hr.
DUE TO (c): ARTERIOSCLERTIC HEART DISEASE — 10 years
Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this hospital) attended the deceased from 12-8-, 1966, to 2-12-, 1967, that (I) (we) last saw the deceased alive an 2-11-19 67 and that death occurred at 3:30 P.M., from causes and on the date stated abave.

22a. SIGNATURE: G Paige Strong — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2/13/67

22c. PHYSICIAN'S NAME (Type): A. PAIGE STRONG, M. D. — 22d. ADDRESS: 167 E. MAIN ST - FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: FEB. 15 '67 — 23c. NAME OF CEMETERY OR CREMATORY: GREENVILLE CEMETERY — 23d. LOCATION (City or Town) (County) (Stote): POCOHONTAS, PA.

24. FUNERAL DIRECTOR — ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD.

25a. REC'D BY REGISTRAR DATE: FEB 16 1967 — 25b. REGISTRAR'S SIGNATURE: J Charles Yeager

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01574

CERTIFICATE OF DEATH

01571

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
c. LENGTH OF STAY IN 1b: 3 Wks.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 211 Hammond

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Barton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Dennis		Lashbaugh	Feb.	1	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White		sept 14, 1895	71 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner	Coal Mine	Allegany-Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jacob Lashbaugh	Laura V. Preston

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	214-01-3756	Isabelle Lashbaugh-Barton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	~~Arteriosclerosis~~ Coronary occlusion	5 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Coronary sclerosis	1 yr
DUE TO (c)	Arteriosclerosis (general)	5 yrs

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April, 1963, to 1 Feb, 1967, that (I) (we) last saw the deceased alive on 27 Jan 1967, and that death occurred at 9:30 pm from the causes and on the date stated above.

22a. SIGNATURE: Norman Reeves M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): E. Norman Reeves, M.D — 22d. ADDRESS: Westernport, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	2/4/67	Mt. View	Moscow Mills, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a.—REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
E. J. Boal	Westernport, Md.	1-6 1967	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01575

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01572

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 6 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 521 Shriver Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Virginia; Middle: Estella; Last: Lillard

4. DATE OF DEATH: Month: February; Day: 11; Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 22, 1900

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John H. Reed

14. MOTHER'S MAIDEN NAME: Myrtle Krause

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 220-52-9466

17. INFORMANT: Wm Harry Lillard
Address: 445 Dirk Street Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion, Left — INTERVAL BETWEEN ONSET AND DEATH: Days
DUE TO
(b): Coronary Sclerosis — --
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of left Hip

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.): Fell at home

20c. TIME OF INJURY Month, Day, Year, Hour o.m.: 10:00 a.m. July 25, 66

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Cumberland, Alleg. Md.

21. I certify that I taak charge of the remains described above, held an Autopsy ☒, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Hamicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: February 11, 1967

Address (Street, city, town, or county): Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/14/67

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland

24. FUNERAL DIRECTOR: H. Lee Silcox
ADDRESS: Cumberland, Maryland 21502

25a. REC'D BY REGISTRAR
DATE: FEB 14 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01576 01573

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND R.F.D.#3
c. LENGTH OF STAY IN 1b: 21 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): BEDFORD ROAD

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.F.D.#3 BEDFORD ROAD, CUMBERLAND 01-
d. STREET ADDRESS: BEDFORD ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CORA Middle ALMA Last LITTLE
4. DATE OF DEATH: Month FEB. Day 12 Year 1967
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC.10, 1883
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (County & State, or foreign country): TWIGGTOWN, MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: MICHAEL S. TWIGG
14. MOTHER'S MAIDEN NAME: JENNIE "MIDDLETON" TWIGG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: 214-05-7961D
17. INFORMANT: MRS KATHRYN TEWELL Address: R.F.D.#3 BEDFORD ROAD CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO
(b): Myocardial Infarctions, old and recent — 1 week (latest)
DUE TO
(c): Hypertensive and Arteriosclerotic CVD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 10, 1960, to Feb 12th, 1967, that (I) (we) last saw the deceased alive on Feb. 12th 1967, and that death occurred at 3 P.M. from causes and on the date stated above.

22a. SIGNATURE: Wyand F. Doerner Jr. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Feb. 13, 1967
22c. PHYSICIAN'S NAME (Type): DR. WYAND F. DOERNER, JR.
22d. ADDRESS: 414 N. MECHANIC ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 15 Feb. 1967
23c. NAME OF CEMETERY OR CREMATORY: HILLCREST BURIAL PARK
23d. LOCATION (City or Town) (County) (State): CUMBERLAND ALLEGANY MD.

24. FUNERAL DIRECTOR: H. LEE SILCOX ADDRESS: 404 DECATUR STREET CUMBERLAND, MARYLAND
25a. REC'D BY REGISTRAR DATE: FEB 15 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01577

01574

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: ALLEGANY	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: PENNA. b. COUNTY: BEDFORD
b. CITY OR TOWN (If outside carporate limits, write RURAL and give neorest town): CUMBERLAND; c. LENGTH OF STAY IN 1b: 11 DAYS	c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): RT. 3, BEDFORD, PA. 75-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL	d. STREET ADDRESS; e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ELSIE	M.	LLEWELLYN	FEB.	23	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
FEMALE	WHITE	WIDOWED [X]	8-5-90	76 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper At Home		MD.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WILLIAM MATTHEWS	ANNIE LOWERY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	205-30-5904	MEMORIAL HOSPITAL CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Pneumonia - due to	
DUE TO (b)	Acute Cor Pulmonale due to	
DUE TO (c)	Chronic Bronchitis, Heart Failure	

5021

Conditians, if any, which gove rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Anteversion Uterus Senile Vaginitis Anemia

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work [ ] Not While at work [ ]	20e. PLACE OF INJURY (Home, form, factary, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1965, 19___, to 2/23, 1967, that (I) (we) last saw the deceased alive on 2/23/67, 19___ and that death occurred at 7:00AM, from causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22b. DATE SIGNED
[signature]		2/24/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
DR. OVERTON HIMMELWRIGHT	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/26/67	Sunset Memorial Park	Cumberland Allegany Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Lee Silcox Cumberland Maryland 21502	FEB 28 1967	[signature]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01578 01575

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland 01-1
d. STREET ADDRESS: 15 N. Chase St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Agnes — Last: Maguire
4. DATE OF DEATH: Month: 2 — Day: 14 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-1-95
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Little Orleans, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Keifer
14. MOTHER'S MAIDEN NAME: Margaret Fahey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: patient's chart — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Hypertrophy Congestive heart failure L+R	3 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic Heart Disease	10 yr
DUE TO (c)	Hypertensive Heart Disease	10 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Multiple Aneurysms of peripheral arteries. The aorta = Thoracic, abdominal; atherosclerosis of the
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 1957, to 2/14, 1967, that (I) (we) last saw the deceased alive on 2/13 1967, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: S G Weisman M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/14/67
22c. PHYSICIAN'S NAME (Type): S G WEISMAN MD
22d. ADDRESS: 54 GREENE ST CUMBERLAND MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb.17,1967
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
23d. LOCATION (City, town or county) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR — DATE: FEB 17 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01579

CERTIFICATE OF DEATH

01576

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 7 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 600 SHRIVER AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First REBECCA Middle Last MARX

4. DATE OF DEATH: Month FEBRUARY Day 22 Year 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-31-1893
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): LITHUANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HAROLD FINE
14. MOTHER'S MAIDEN NAME: FLORENCE ROSENTHAL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Terminal congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO (b): Myocardial infarction, antero-septal — 3 months.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): A.S. Cardiovascular Disease — 3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Gen. arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 4 Dec., 1966, to 22 Feb., 1967 that (I) (we) last saw the deceased alive on 21 Feb. 1967, and that death occurred at 2:25 P.M., from causes and on the date stated above.

22a. SIGNATURE: W. Alfred Van Ormer M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 22 Feb. 67
22c. PHYSICIAN'S NAME (Type): DR. W.A. VAN ORMER
22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/23/67
23c. NAME OF CEMETERY OR CREMATORY: East View Cemetery
23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Md.

24. FUNERAL DIRECTOR: Louis Stein, Inc. ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: FEB 27 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

1 (M)

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01580

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01577

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LaVale Md.
c. LENGTH OF STAY IN 1b: 25yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 539 National Highway LaVale Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LaVale Maryland
d. STREET ADDRESS: 539 National Hwy.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lee; Middle B.; Last Mathews

4. DATE OF DEATH: Month February; Day 20; Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 6, 1891

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Medical Doctor

10b. KIND OF BUSINESS OR INDUSTRY: Doctor

11. BIRTHPLACE (State or foreign country): Maysville Ga.

12. CITIZEN OF WHAT COUNTRY? U.S. A.

13. FATHER'S NAME: William Asbury Mathews

14. MOTHER'S MAIDEN NAME: Carrie Rosa Porter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): WWI

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs. Carrie Mathews 539 National Hwy.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): CORONARY SCLEROSIS
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m.; 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

22. DATE SIGNED: February 20, 1967

Address (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/23/67

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION (City, town or county) (State): Cumberland Maryland

24. FUNERAL DIRECTOR ADDRESS: Louis Stein Inc. 117 Frederick St.

25a. REC'D BY REGISTRAR DATE: FEB 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Yeager

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 5M 1/65

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X

X

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G386 3/13/67 pc

01581

CERTIFICATE OF DEATH

01578

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 6/8/1913
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: FURNACE STREET EXT.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John — Middle — Lost Mavinick

4. DATE OF DEATH: Month February — Doy 19, — Year 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: UNKNOWN
9. AGE (In yeors last birthday): UNKNOWN — IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (County & Stote, or foreign country): UNKNOWN
12. CITIZEN OF WHAT COUNTRY? UNKNOWN

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: P.O.Box 599, Cumberland, Md. Allegany County Home records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypocardiac Arr. degeneration Senile
DUE TO (b): Arteriosclerosis generalized Cerebral
DUE TO (c): Bilateral leg amputation (at Hips)
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost. — From Auto Accident 1913.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that (I) (this hospital) attended the deceased from 6/8/1913, 19___, to 2/19/, 1967, that (I) (we) last saw the deceased alive on 2/18/ 1967, and that death occurred at 8:25 A.M., from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒
22b. DATE SIGNED: 2/20/1967
22c. PHYSICIAN'S NAME (Type): Lee B. Mathews, M. D.
22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: FEB. 21, 1967
23c. NAME OF CEMETERY OR CREMATORY: ALLEGANY COUNTY CEMETERY
23d. LOCATION (City or Town) (County) (Stote): CUMBERLAND, MD.

24. FUNERAL DIRECTOR: BYRON KIGHT — ADDRESS: CUMBERLAND, MD.
25a. RECD BY REGISTRAR DATE: FEB 27 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01582 01579

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 146 Hanover Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Frederick Last: McCormick

4. DATE OF DEATH: Month: 2 Day: 17 Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/14/06

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Cumberland, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles McCormick

14. MOTHER'S MAIDEN NAME: Anna Pleasant

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 220 17 6855

17. INFORMANT: Patient's Chart Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Right Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Bronchiectasis — 20 years
DUE TO (c):

526X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pulmonary Fibrosis Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-11, 1967, to 2-17, 1967, that (I) (we) last saw the deceased alive on 2-16 1967, and that death occurred at 2a M, from the causes and on the date stated above.

22a. SIGNATURE: Ralph W. Ballin M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-17-67

22c. PHYSICIAN'S NAME (Type): Ralph W. Ballin, M.D.

22d. ADDRESS: 62 Greene St. Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (Soecify): BURIAL

23b. DATE THEREOF: FEB. 20,1967

23c. NAME OF CEMETERY OR CREMATORY: GREENMOUNT CEMETERY

23d. LOCATION (City, town or county) (State): CUMBERLAND, MD.

24. FUNERAL DIRECTOR: BYRON KIGHT ADDRESS: CUMBERLAND, MD.

25a. REC'D BY REGISTRAR DATE: FEB 21 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

x

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01583 01580

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 7/1/1960
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Frostburg
d. STREET ADDRESS: 19 Washington Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary; Middle; Last McDonald
4. DATE OF DEATH: Month February Day 6, Year 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/19/1875
9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired: Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY: Housekeeping
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: John McDonald
14. MOTHER'S MAIDEN NAME: Alice Halfpenny
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 578-44-3306
17. INFORMANT: P.O.Box 599, Address: Cumberland, Md. Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): (1) Myocarditis, Chr. degenerative — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): (2) Arterio Sclerosis, General —
DUE TO (c): (3) Cerebral apoplexy & Rt Hemiplegia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/1/1960, 19___ to 2/6/1967 19___, that (I) (we) last saw the deceased alive on 2/4/1967 19___, and that death occurred at 7:50 A.M. from causes and on the date stated above. (at 7:50 A.M.)

22a. SIGNATURE: Lee B. Mathews M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒
22b. DATE SIGNED: 2/6/1967
22c. PHYSICIAN'S NAME (Type): Lee B. Mathews, M. D.
22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: FEB.9,1967
23c. NAME OF CEMETERY OR CREMATORY: ST. MICHAEL'S CEM.
23d. LOCATION (City or Town) (County) (State): FROSTBURG MARYLAND

24. FUNERAL DIRECTOR: MARILOU M. SOWERS
ADDRESS: HAFER FUNERAL HOME 60 W. MAIN, FROSTBURG
25a. REC'D BY REGISTRAR DATE: FEB 10 1967
25b. REGISTRAR'S SIGNATURE: Rhoda, Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01584 — 01581

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 14 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND — 01-1
d. STREET ADDRESS: 26 BOONE STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY — Middle E. — Last MICHAEL
4. DATE OF DEATH: Month FEBRUARY — Day 25 — Year 19 67
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐
8. DATE OF BIRTH: 3-27-1886
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind af work done during most of working life, even if retired): RETIRED Machinist
10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD
11. BIRTHPLACE (County & State, or foreign country): WESTERNPORT, MD.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: WILLIAM A. MICHAEL
14. MOTHER'S MAIDEN NAME: ADA MEASE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, ar unknown): no — (If yes give wor or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MEMORIAL HOSPITAL-CUMBERLAND, MD. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly ane cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 14
DUE TO (b): Arteriosclerotic Cardio Vascular Disease
DUE TO (c):
Conditions, if ony, which gave rise to immediate couse (a), stating the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in Part I ar Part II af item 18.)
20c. TIME OF INJURY Manth, Day, Year — Haur a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City ar town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1954, 19__ to 1967, 19__, that (I) (we) last saw the deceased alive an Feb 21, 19 67, and that death occurred at 2:20 P.M., from causes and an the date stated above.

22a. SIGNATURE — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/27/67
22c. PHYSICIAN'S NAME (Type): DR. G. O. HIMMELWRIGHT
22d. ADDRESS: 133 VIRGINIA AVE., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb.28,1967
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City or Town) (County) (State): Cumberland,Md.Allegany

24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md. — ADDRESS
25a. REC'D BY REGISTRAR DATE: MAR 1 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01585

CERTIFICATE OF DEATH

01582

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): LAVALE
01-1
d. STREET ADDRESS: 9 CAMP GROUND RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERNICE Middle VIRGINIA Last NIES

4. DATE OF DEATH: Month FEBRUARY Day 16 Year 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-4-01

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S. A.

13. FATHER'S NAME: ISSAC LONG

14. MOTHER'S MAIDEN NAME: HAWK, AUGUSTA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 220-28-9763

17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b): Arteriosclerosis Cerebral Vascular Disease — Years
DUE TO
(c):
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1960, 3:15 to P.M. 2/16, 1967, that (I) (we) last saw the deceased alive on 2/16 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/19/67

22c. PHYSICIAN'S NAME (Type): DR. G. OVERTON HIMMELWRIGHT

22d. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Feb.19,1967	Hillcrest Burial Park	Cumberland,Md.Allegany

24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: FEB 24 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01586

CERTIFICATE OF DEATH

01583

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 5/12/1965
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 511 Fayette St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie — Middle: Lee — Lost: O'Baker

4. DATE OF DEATH: Month: February — Doy: 6, — Year: 1967

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: 5/28/1880 — 9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Caretaker — 10b. KIND OF BUSINESS OR INDUSTRY: Private Club — 11. BIRTHPLACE (County & Stote, or foreign country): Flintstone, Maryland — 12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: John William Thompson — 14. MOTHER'S MAIDEN NAME: Sara Elbin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No. — 16. SOCIAL SECURITY NO.: 235-32-7015 — 17. INFORMANT: P.O.Box 599, Address: Cumberland, Md. Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): (1) Pneumonitis, Chs. Degeneration Senile — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): (2) Arteriosclerosis, General & Cerebral
Conditions, if ony, which gave rise to immediate couse (o), stoting the underlying couse last. DUE TO (c): (3) Bilateral Cataracts
422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 — 20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐ — 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 5/12/1965, 19___, to 2/6/1967 19___, that (I) (we) last saw the deceased alive an 2/6/1967 19___, and that death accurred at at 9:40 A.M., from causes and an the date stated abave.

22a. SIGNATURE: [signature] — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒ — 22b. DATE SIGNED: 2/6/1967

22c. PHYSICIAN'S NAME (Type): Lee B. Mathews, M. D. — 22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2/9/67 — 23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cemetery — 23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR — ADDRESS: H. Wayne George Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: FEB 9 1967 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01587

CERTIFICATE OF DEATH

01584

1. PLACE OF DEATH
a. COUNTY: Allegany
MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Westernport
c. LENGTH OF STAY IN 1b: 23 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): 506 Maryland Ave.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest tawn): Westernport
d. STREET ADDRESS: 506 Maryland Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James Middle: Joseph Last: Pamepinto
4. DATE OF DEATH: Month: Feb. Doy: 21 Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 15, 1917
9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Digestor Operator
10b. KIND OF BUSINESS OR INDUSTRY: Paper Mill
11. BIRTHPLACE (County & Stote, or foreign country): Mineral-West Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Peter Pamepinto
14. MOTHER'S MAIDEN NAME: Virginia Caldrone
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): no
16. SOCIAL SECURITY NO.: 217-05-0987
17. INFORMANT Address: Gladys Pamepinto-Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac arrest
DUE TO (b): Myocardial Infarction
DUE TO (c):
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that (I) (this hospital) attended the deceased from 2-21-, 1967, to ____, 19__, that (I) (we) last saw the deceased alive on 2-19 1967, and that death occurred at 5:55 M, from causes and on the date stoted obave.

22a. SIGNATURE: Robert W. Bess Jr. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2-21-67
22c. PHYSICIAN'S NAME (Type): Robert W. Bess, Jr.
22d. ADDRESS: Piedmont, W.Va.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/23/67
23c. NAME OF CEMETERY OR CREMATORY: Philos
23d. LOCATION (City or Town) (County) (Stote): Westernport, Md

24. FUNERAL DIRECTOR: E. L. Beal
ADDRESS: Westernport, Md.
25a. REC'D BY REGISTRAR DATE: FEB 23 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Lindsay

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01588

CERTIFICATE OF DEATH

01585

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 HOUR 13 MINUTES
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: PENNSYLVANIA — b. COUNTY: BEDFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SPRINGS
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LOLA — Middle V. — Last PECK

4. DATE OF DEATH: Month FEB. — Day 21 — Year 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 9-2-1909

9. AGE (In years last birthday): 57 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): FORT HILL, PA.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: HENRY LIVINGOOD

14. MOTHER'S MAIDEN NAME: NELLIE GROVE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hodgkins Disease — INTERVAL BETWEEN ONSET AND DEATH: Since 1964
201X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-21-, 1967 to 2-21-, 1967, that (I) (we) last saw the deceased alive on 2-21- 19 67, and that death occurred at 11:5 M, from causes and on the date stated above.

22a. SIGNATURE: W. F. Williams M.D. — ATTENDING PHYS. ☐ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 2-22-67

22c. PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS

22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2-24-67

23c. NAME OF CEMETERY OR CREMATORY: Maple Glen

23d. LOCATION (City or Town) (County) (State): Springs Somerset Co Pa

24. FUNERAL DIRECTOR — ADDRESS: Don Newman Grantsville, Md.

25a. REC'D BY REGISTRAR DATE: MAR 1 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01589 — 01586

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Lonaconing
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address): Kyle Nurseing Home

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest tawn): Lonaconing
d. STREET ADDRESS: East Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type ar print): First MARY — Middle JANE — Last PEEBLES

4. DATE OF DEATH: Month 2/28/1967 — Day — Year 19

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/30/~~89~~ 1878

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or fareign country): Lonaconing, MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Gunning

14. MOTHER'S MAIDEN NAME: Margaret Price

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dotes of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: ROBERT PEEBLES (SON) Lonaconing, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Ischemia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause lost.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Senile Psychosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in Part I ar Part II of item 18.)

20c. TIME OF INJURY Manth, Day, Year Haur o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Hame, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceosed from _____, 19 58, to Feb. 28, 1967, that (I) (we) last saw the deceased alive on Feb 23 19 67, and thot deoth occurred at _____ M, from couses ond on the dote stated above.

22a. SIGNATURE: L.R. Miles Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-28-67

22c. PHYSICIAN'S NAME (Type): L.R. MILES, JR., M.D.

22d. ADDRESS: LONACONING MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/3/1967

23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery

23d. LOCATION (City or Tawn) (County) (State): Lonaconing, MD.

24. FUNERAL DIRECTOR: GEORGE EICHHORN — ADDRESS: Lonaconing, MD.

25a. REC'D BY REGISTRAR DATE: MAR 2 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01590

CERTIFICATE OF DEATH

01587

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sylvan Retreat

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: East Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: A. — Last: Plummer

4. DATE OF DEATH: Month: Feb. — Day: 13 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/19/90

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY: SELF-EMPLOYED

11. BIRTHPLACE (County & State, or foreign country): SHAFT Allegany, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Louis A. Plummer

14. MOTHER'S MAIDEN NAME: AMANDA Michaels

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 219-03-8851

17. INFORMANT: MR. ALGIE PLUMMER, E. MAIN STREET — Address: FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): (1) Diabetes, Mellitus & Coma
DUE TO: (2) Cerebral Apoplexy -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: (3) Arteriosclerosis General
(c) Cerebral -
260X
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 10, 1967, to Feb. 13, 1967, that (I) (we) last saw the deceased alive on Feb. 12 1967, and that death occurred at 1A.M, from causes and on the date stated above.

22a. SIGNATURE: L. B. Mathews M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): L. B. Mathews, M.D.

22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: FEB. 15, 1967

23c. NAME OF CEMETERY OR CREMATORY: FROSTBURG MEM. PARK

23d. LOCATION (City or Town) (County) (State): FROSTBURG MARYLAND

24. FUNERAL DIRECTOR: MARILOU M. SOWERS — ADDRESS: HAFER FUNERAL HOME 60 W. MAIN ST., FROSTBURG
Marilou M. Sowers

25a. REC'D BY REGISTRAR DATE: FEB 17 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01591 — 01588

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deloy is necessory, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forworded to the Chief Medical Exominer's Office olong with form PM3. Page 5 may be retoined for your files.

TO FUNERAL DIRECTOR: Page 3 should be used os o buriol-transit permit. File pages 1 and 2 with the State Department of Health or its designoted ogent, prior to buriol, cremation, or removol, and in any event within 72 hours after deoth.

VR A15ME (5) 6M 1/66

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberalnd
c. LENGTH OF STAY IN 1b: 40 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 328 Fayette

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 328 Fayette
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Pansy — Middle: — Last: Porter

4. DATE OF DEATH: Month: Feb. — Day: 28 — Year: 1967

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: Dec. 6, 1883 — 9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H. Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lawson Montgomery
14. MOTHER'S MAIDEN NAME: Lousia Kight

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mrs. Leafy Matthews—Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudd en
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary Sclerosis
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my apinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Cumberland, Md.

22. DATE SIGNED: February 28, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/3/67
23c. NAME OF CEMETERY OR CREMATORY: Philos
23d. LOCATION (City or Town) (County) (State): Westernport Md.

24. FUNERAL DIRECTOR: E. L. Beal — ADDRESS: Westernport, Md.

25a. REC'D BY REGISTRAR DATE: MAR 3 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01592

CERTIFICATE OF DEATH

01589

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): FROSTBURG
c. LENGTH OF STAY IN 1b: 2 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS: 131 MT. PLEASANT ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARIA Middle G. Lost QUARTUCCI

4. DATE OF DEATH: Month FEBRUARY Doy 15, Year 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: APRIL 8, 1888
9. AGE (In yeors last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (County & State, or foreign country): CELICO COSENZA, ITALY
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: GAETANO GRECO
14. MOTHER'S MAIDEN NAME: CHIRA MELE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): NO
16. SOCIAL SECURITY NO.: 212-54-8041
17. INFORMANT: MRS. LAWRENCE TUMMINO, 131 MT. PLEASANT ST., FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Pneumonitis — 10 days
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost. 492X
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Aneurysm of Ascending Aorta

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/2, 1967, to 2/15, 1967, thot (I) (we) last saw the deceased alive on 2/15 1967, and that death occurred at 9:05 M, from causes and on the date stoted obave.

22a. SIGNATURE: Marshall Rothstein M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/16/67
22c. PHYSICIAN'S NAME (Type): MARTIN M. ROTHSTEIN, M.D.
22d. ADDRESS: 48 BROADWAY, FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: FEB. 18, 1967
23c. NAME OF CEMETERY OR CREMATORY: SUNSET MEMORIAL PARK
23d. LOCATION (City or Town) (County) (State): CUMBERLAND, MARYLAND

24. FUNERAL DIRECTOR: MARILOU M. SOWERS
ADDRESS: HAFER FUNERAL HOME 60 W. MAIN, FROSTBURG
Marilou M. Sowers
25a. RECD BY REGISTRAR DATE: FEB 20 1967
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01593

CERTIFICATE OF DEATH

01590

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside carparate limits, write RURAL and give neorest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
d. STREET ADDRESS: State Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: — Last: Rankin
4. DATE OF DEATH: Month: February — Day: 26 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11/25/1874
9. AGE (In years last birthday): 92 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Lonaconing, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Rankin
14. MOTHER'S MAIDEN NAME: Ann Scott
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. John Shockey "Daughter" — Address: Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO (b): Arteriosclerosis — years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4500

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 1960, to Feb. 26, 1967, that (I) (we) last saw the deceased alive on Feb 26 1967, and that death occurred at 2 A M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2.27.67
22c. PHYSICIAN'S NAME (Type): L.R. MILES, VR
22d. ADDRESS: LONACONING MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/28/67
23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Moscow A. Md.

24. FUNERAL DIRECTOR: George Eichhorn — ADDRESS: Lonaconing, Md.
25a. REC'D BY REGISTRAR DATE: MAR 1 1967
25b. REGISTRAR'S SIGNATURE: [signature] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01594

CERTIFICATE OF DEATH

01591

1. PLACE OF DEATH
a. COUNTY: Allegany
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 6/15/1966
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
01-1
d. STREET ADDRESS: 30½ Virginia Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Martha Middle Williams Last Ronnie Mc Kendrick
4. DATE OF DEATH: Month Feb. Day 11 Year 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/24/1889
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired:Chargehand
10b. KIND OF BUSINESS OR INDUSTRY: at Celanese Corp.
11. BIRTHPLACE (County & State, or foreign country): Eckhart, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Alex Williams
14. MOTHER'S MAIDEN NAME: Catherine Willson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service): no
16. SOCIAL SECURITY NO.: 217-10-5432
17. INFORMANT: P.O.Box 599, Address Cumberland,Md. Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ① Arterio Sclerotic cardiovascular
DUE TO (b): disease ② Hypertension ③ Cerebral
DUE TO (c): apoplexy ④ Left Hemiplegia
443X
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/15/1966, 19___, to 2/11/67, 19___, that (I) (we) last saw the deceased alive on 2/11/67 19___, and that death occurred at P. M. at 6:10 P.M., from causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒
22b. DATE SIGNED: 2/13/1967
22c. PHYSICIAN'S NAME (Type): Lee B. Mathews, M. D.
22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb.14,1967
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City or Town) (County) (State): Cumberland,Md.Allegany

24. FUNERAL DIRECTOR: James F. Scarpelli, ADDRESS: Cumberland,Md.
25a. REC'D BY REGISTRAR DATE: FEB 15 1967
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

01354

01391

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01595 01592

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Savage
d. STREET ADDRESS: 01-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Albert — Middle — Last Rice
4. DATE OF DEATH: Month 2/ Day 12/ Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/22/1894
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired foreman
10b. KIND OF BUSINESS OR INDUSTRY: State Road Dept.
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George P. Rice
14. MOTHER'S MAIDEN NAME: Sadie Reeser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 214-07-0303
17. INFORMANT Address: Albert P. Rice, Corrigansville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 mo.
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Arteriosclerotic Heart Disease — 30 yrs.
DUE TO (c): Generalized arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
None
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 1, 1965, to Feb. 12, 1967, that (I) (we) last saw the deceased alive on Feb. 12, 1967, and that death occurred at 1:45 PM from the causes and on the date stated above.

22a. SIGNATURE: James P. Hallinan M.D.
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2-14-67
22c. PHYSICIAN'S NAME (Type): James P. Hallinan M. D.
22d. ADDRESS: 140 Bedford St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb. 14, 1967
23c. NAME OF CEMETERY OR CREMATORY: Methodist Cemetery
23d. LOCATION (City, town or county) (State): Mt. Savage, Md.

24. FUNERAL DIRECTOR ADDRESS: Joseph R. Durst, Sr., Frostburg, Md.
25a. REC'D BY REGISTRAR DATE: FEB 16 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01596

CERTIFICATE OF DEATH

01593

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 9 HOURS 20 MINUTES
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 30 RACE STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
VIRGINIA	E.	SCATURRO	FEBRUARY	17,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE		3-26-1920	46 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machine Operator	Textile	CUMBERLAND, MD.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
SYLVESTER PITTMAN	NORA SHAD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no		MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): & Myocardial Infarction — 9 hours
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factary, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) attended the deceased from June, 1963 to Feb. 17, 1967, thot (I) (we) last saw the deceased alive on Feb. 17 1967, and that death occurred at 8:50 A.M., from causes and on the date stated above.

22a. SIGNATURE: Clay E. Durrett — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2/18/67

22c. PHYSICIAN'S NAME (Type): DR. CLAY E. DURRETT — 22d. ADDRESS: 236 VIRGINIA AVE., CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Feb.19,1967	Hillcrest Burial Park	Cumberland,Md.Allegany

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	FEB 23 1967	J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01597

CERTIFICATE OF DEATH

01594

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 32 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside carporate limits, write RURAL and give neorest town): CUMBERLAND
d. STREET ADDRESS: 415 GREENE STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First IDA Middle CHRISTINA Lost SCHILLING

4. DATE OF DEATH: Month FEBRUARY Day 12 Year 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-20-1877
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: LEWIS WEBER
14. MOTHER'S MAIDEN NAME: Sarah Enos

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No,
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: MEMORIAL HOSPITAL-CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(b): hepfuzzlegrum — 5 years
DUE TO
(c): Arteriosclerotic cardiovascular disease — 20 years

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary infection

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from [illegible], 19[illegible] to 2/12, 1967, that (I) (we) last saw the deceased alive on 2/11 1967, and that death occurred at 1:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/14/67
22c. PHYSICIAN'S NAME (Type): DR. S.G. WEISMAN
22d. ADDRESS: 59 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/14/67
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR: H. Wayne George
ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: FEB 17 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01598

CERTIFICATE OF DEATH

01595

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Cumberland
c. LENGTH OF STAY IN 1b: 50 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany Co. Infirmy

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: allegany
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Cumberland
d. STREET ADDRESS: 30 N. Liberty St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: Ray — Lost: Sechler

4. DATE OF DEATH: Month: February — Doy: 11, — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 12, 1889
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad
10b. KIND OF BUSINESS OR INDUSTRY: B&O Railroad
11. BIRTHPLACE (County & State, or foreign country): Paddytown Somerset Co. Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles H. Sechler
14. MOTHER'S MAIDEN NAME: Minnie Otto

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Miss Blanche Sechler — Address: Somerset Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 151X — ① Carcinoma of Stomach & Gastro-Colonic Fistula ② Myocarditis
DUE TO (b): Chr. degeneration ③ Arterio Sclerosis
DUE TO (c): General ④ Arthritis of Spine
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Haur a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/13/67
23c. NAME OF CEMETERY OR CREMATORY: Kingwood I.O.O.F. Cem.
23d. LOCATION (City or Town) (County) (State): Kingwood Somerset Penna.

24. FUNERAL DIRECTOR: James Stein Inc. — ADDRESS: Cumb. Md.
25a. REC'D BY REGISTRAR DATE: FEB 15 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01599

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01596

1 (M) FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
c. LENGTH OF STAY IN 1b: 51 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Charlestown St.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
d. STREET ADDRESS: Charlestown Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle O — Last SHOCKEY

4. DATE OF DEATH: Month 2/2/1967 — Day — Year 19

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/10/1915

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lonaconing

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Ricker

14. MOTHER'S MAIDEN NAME: Myrtle Metz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: CHARLES SHOCKEY (HUSBAND) Address: Lonaconing, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
4201
DUE TO
(b): CORONARY SCLEROSIS — ---
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot I took chorge of the remoins described obove, held on Autopsy ☐, Inspection ☒, Inquiry ☒, ond in my opinion deoth resulted from: Noturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒☒
(Name of city, town or county): Cumberland, MD

22. DATE SIGNED: 2/2/1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/4/1967
23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Lonaconing MD.

24. FUNERAL DIRECTOR: George Eichhorn
ADDRESS: Lonaconing, MD.

25a. REC'D BY REGISTRAR DATE: FEB 6 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01600 — 01597

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: ALLEGANY — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND — b. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG — c. LENGTH OF STAY IN 1b: 6 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG 01-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): MINERS HOSPITAL 51	d. STREET ADDRESS: 61 BROADWAY — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Lost	4. DATE OF DEATH Month	Doy	Year
ANNIE	HAYES	SMITH	FEBRUARY	26,	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In yeors lost birthday)	IF UNDER 1 YEAR Months	Doys	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE		MAY 5, 1880	86 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & Stote, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	OWN HOME	FROSTBURG, MD.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WILLIAM HOPKINS	JANET ANWYEL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT (Name) (Address)
NO	213-16-9071	MRS. LESTER BRENNEMAN, GUNTER HOTEL FROSTBURG, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): arteria-Sclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: —

DUE TO (b): Hypertension — —

DUE TO (c): Arthritis-major joints —

Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying couse lost. 4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility 2

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (Stote)

21. I certify that (I) (~~this hospital~~) attended the deceased from 6-1, 1965, to 2-26, 1967, that (I) (~~we~~) last saw the deceased alive an 2-25 1967, and that death occurred at 2:30 A.M., from causes and an the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22b. DATE SIGNED
H. C. Diehl					2/27/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
H. C. DIEHL, M.D.	39 W. MAIN ST., FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)
BURIAL	FEB. 28, 1967	FROSTBURG MEM. PARK	FROSTBURG, MARYLAND

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
MARILOU M. SOWERS Marilou M. Sowers	HAFER FUNERAL HOME 60 W. MAIN, FROSTBURG	MAR 2 1967	Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01601 — 01598

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1200 Bedford Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland — 01-1
d. STREET ADDRESS: 1200 Bedford Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Albert Otto — Last: Smith

4. DATE OF DEATH: Month: February — Day: 23 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 9, 1887

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoe Store Owner

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Conrad George Smith

14. MOTHER'S MAIDEN NAME: Amelia Damm

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): W W 1

16. SOCIAL SECURITY NO.: 1538

17. INFORMANT: Mrs. Ruth Elizabeth Smith — Address: 1200 Bedford St Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Adenocarcinoma Sigmoid

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Edema Cerebri Colon
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 1 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year / Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/26/64, 19__ to 2/23/67, 19__ that (I) (we) last saw the deceased alive on 2/21/67 19__, and that death occurred at 7:30 M, from the causes and on the date stated above.

22a. SIGNATURE: R. J. Williams — ATTENDING M.D. PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/24/67

22c. PHYSICIAN'S NAME (Type): R. J. Williams

22d. ADDRESS: 122 S. Centre St., Cumberland, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 26, 1967

23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

23d. LOCATION (City, town or county) (State): Cumberland, Md

24. FUNERAL DIRECTOR: John J. Hafer, Jr. — ADDRESS: 230 Balto Ave, Cumberland

25a. REC'D BY REGISTRAR DATE: FEB 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G386 3/13/67 pf

01602

CERTIFICATE OF DEATH

01599

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Allegany	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland	c. LENGTH OF STAY IN 1b: 17 years
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland	01-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sylvan Retreat	d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒	
3. NAME OF DECEASED (Type or print): First Martin, Middle, Last Smock	4. DATE OF DEATH: Month Feb. Day 24 Year 19 67
5. SEX: Male	6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ Unk. DIVORCED ☐	8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): Unk. 80 yrs.	IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown	10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (County & State, or foreign country): Unknown	12. CITIZEN OF WHAT COUNTRY? Unk.
13. FATHER'S NAME: Unknown	14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes give war or dates of service)	16. SOCIAL SECURITY NO.: 220-52-9961
17. INFORMANT Address: Sylvan Retreat, Cumberland, Md. (County)	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Anaemia	3 days
DUE TO (b)	Myocarditis & Decompensation	2 yrs
DUE TO (c)	Arteriosclerosis	10 yrs.

4221

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 6, 19 50, to Feb. 24, 19 67, that (I) (we) last saw the deceased alive on Feb. 24 19 67, and that death occurred at 4 P M, from causes and on the date stated above.

22a. SIGNATURE: Clay E. Durrett M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/25/67

22c. PHYSICIAN'S NAME (Type): Clay E. Durrett, M.D.

22d. ADDRESS: 236 Virginia Ave., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Feb.27,1967	Allegany County Cemetery	Cumberland Md. Allegany

24. FUNERAL DIRECTOR: James F. Scarpelli ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: MAR 1 1967

25b. REGISTRAR'S SIGNATURE: [illegible] judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01603

CERTIFICATE OF DEATH

01600

1. PLACE OF DEATH
a. COUNTY Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
c. LENGTH OF STAY IN 1b: 16 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacared Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 01-1
d. STREET ADDRESS 465 Warren Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Guilio Middle Nmi Last Squillari
4. DATE OF DEATH: Month 2 Day 11 Year 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/19/10
9. AGE (In years last birthday): (56) XXX yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chef
10b. KIND OF BUSINESS OR INDUSTRY: Resturaunt
11. BIRTHPLACE (County & State, or foreign country): Italy, Mornbercelli
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Eugenio Squillari
14. MOTHER'S MAIDEN NAME: Mary Ferrero

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 219-34-6002
17. INFORMANT: Sacred Heart Address: Decatur St, Cumberland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
2Df. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Dec, 1966, to 2-11, 1967, that (I) (~~we~~) last saw the deceased alive on 2-11 1967, and that death occurred at 9P M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2-14-67
22c. PHYSICIAN'S NAME (Type) L. MICHAEL GLICK
22d. ADDRESS 126 N. SMALLWOOD ST CUMBERLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb. 14, 1967
23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cemetery
23d. LOCATION (City, town or county) (State): Cumberland Md. Allegany

24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: FEB 15 1967
25b. REGISTRAR'S SIGNATURE: [signature] Deputy Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film G386 3/6/67 mh

01604

CERTIFICATE OF DEATH

01601

1. PLACE OF DEATH
   a. COUNTY: ALLEGANY
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 15 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG,
   d. STREET ADDRESS: 206 MC CULLOUGH ST.,
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First GODFREY; Middle D.; Last STOTT

4. DATE OF DEATH: Month FEBRUARY; Day 26; Year 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-22-1907 (1905)

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: W.MD. R.R.CO.

11. BIRTHPLACE (County & State, or foreign country): FROSTBURG, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN STOTT

14. MOTHER'S MAIDEN NAME: LAURA DAVIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 212-14-1635A

17. INFORMANT Address: MEMORIAL HOSPITAL-CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Heart Disease
DUE TO (b): and Myocardial Infarction
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
4201
INTERVAL BETWEEN ONSET AND DEATH: 1 Yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot (I) (this hospitol) attended the deceased from 2/7/67, 19__ to 2/26/67, 19__, thot (I) (we) last saw the deceased alive on 2/25/67 19__, and that death accurred at 5:30 A.M., from causes and on the dote stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/26/67

22c. PHYSICIAN'S NAME (Type): DR. R.J. WILLIAMS

22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-1-67

23c. NAME OF CEMETERY OR CREMATORY: St Anns Cemetery

23d. LOCATION (City or Town) (County) (State): Avilton Garrett Md

24. FUNERAL DIRECTOR ADDRESS: Joseph R. Dent Frostburg Md

25a. REC'D BY REGISTRAR DATE: MAR 2 1967

25b. REGISTRAR'S SIGNATURE: [signature] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01605

CERTIFICATE OF DEATH

01602

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 227 CARROLL ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELLA Middle MAE Last TAYLOR

4. DATE OF DEATH: Month FEBRUARY Day 24, Year 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12-17-1889

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper - At Home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: LAFAYETTE MOXLEY

14. MOTHER'S MAIDEN NAME: MARGARET SHILLING

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 213-03-7977

17. INFORMANT: Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion
DUE TO (b): Diabetic Arteriosclerotic Hypertension
DUE TO (c): Cerebro Vascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
260X
INTERVAL BETWEEN ONSET AND DEATH: Hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1951, 19__ to 1967, 19__, that (I) (we) last saw the deceased alive on 2/23/67, 19__, and that death occurred at 5:15 P.M. from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/24/67

22c. PHYSICIAN'S NAME (Type): DR. G. O. HIMMELWRIGHT

22d. ADDRESS: VIRGINIA AVE.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/26/67

23c. NAME OF CEMETERY OR CREMATORY: RoseHill Cemetery

23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland

24. FUNERAL DIRECTOR: H. Lee Silcox ADDRESS: Cumberland Maryland 21502

25a. REC'D BY REGISTRAR DATE: FEB 28 1967

25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01606

CERTIFICATE OF DEATH

01603

1. PLACE OF DEATH
a. COUNTY ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
c. LENGTH OF STAY IN 1b 8 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
d. STREET ADDRESS 120 W. OFFUTT ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First DAVID Middle T. Last THARP
4. DATE OF DEATH Month FEBRUARY Day 28 Year 1967
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2-20-96
9. AGE (In years last birthday) 71 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATOR
10b. KIND OF BUSINESS OR INDUSTRY PLANT NURSERY
11. BIRTHPLACE (County & State, or foreign country) MARTINSBURG, W.VA.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME HARVEY THARP
14. MOTHER'S MAIDEN NAME ELIZABETH SHAD
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WW 1
16. SOCIAL SECURITY NO. 217 48 7086
17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH 2 wks
DUE TO (b) Myocarditis & Decompensation — 3 wks
DUE TO (c) Arteriosclerosis — 3 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4221
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 10, 19 67, 8:19 to P.M. Feb 28 19 67 that (I) (we) last saw the deceased alive on Feb. 28 19 67, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE Clay E. Durrett M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 3/28/67
22c. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT
22d. ADDRESS CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF MARCH 3, 1967
23c. NAME OF CEMETERY OR CREMATORY DAVIS MEMORIAL BURIAL PARK
23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.

24. FUNERAL DIRECTOR BYRON KIGHT
ADDRESS CUMBERLAND, MD.
25a. REC'D BY REGISTRAR DATE MAR 6 1967
25b. REGISTRAR'S SIGNATURE J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01607 Item #14 infor. taken from birth cert. 01604

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): MIDLOTHIAN
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RUTH — Middle MARION — Lost TROUTMAN

4. DATE OF DEATH: Month 2 — Day 9 — Year 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/18/66

9. AGE (In yeors last birthday) yrs.

IF UNDER 1 YEAR: Months 2 — Days 15
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N.A.

10b. KIND OF BUSINESS OR INDUSTRY: N.A.

11. BIRTHPLACE (State or foreign country): FROSTBURG, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: RAY LEROY TROUTMAN

14. MOTHER'S MAIDEN NAME: RUTH GORDON / Marion Cecilia Gordon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): N.A. (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: N.A.

17. INFORMANT Address: MR. GEORGE GORDON, MIDLOTHIAN, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): LOBAR PNEUMONIA, BILATERAL — INTERVAL BETWEEN ONSET AND DEATH: DAYS
491X
DUE TO
(b): STREPTOCOCCUS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: FEBRUARY 9, 1967

Address (Street, city, town, or county): CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: FEB. 12, 1967
23c. NAME OF CEMETERY OR CREMATORY: FROSTBURG MEM. PARK
23d. LOCATION (City or Town) (County) (State): FROSTBURG, MARYLAND

24. FUNERAL DIRECTOR: MARILOU M. SOWERS
ADDRESS: HAFER FUNERAL HOME, 60 W. MAIN, FROSTBURG
Marilou M. Sowers
6-201469

25a. RECD BY REGISTRAR DATE: FEB 14 1967

25b. REGISTRAR'S SIGNATURE: Charles Judy

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01608 — 01605

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: ALLEGANY MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): FROSTBURG c. LENGTH OF STAY IN 1b: 9 DAYS	c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): MIDLOTHIAN 01-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MINERS HOSPITAL	d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ISABELLE	H.	WALKER	FEBRUARY	8,	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE		FEB. 25, 1916	50 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEKEEPER	PRIVATE HOME	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JAMES WALKER	JANET BRIMLOW

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
	214-05-9803	MRS. RUTH LASHBAUGH,	FROST VILLAGE, FROSTBURG, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Massive Coronary Occlusion	30 minutes
DUE TO (b)	Arteriosclerotic C.V.D.	15 yrs.
DUE TO (c)	Diabetes Mellitus	15 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
X	X

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
X	X	X	X		

21. **I certify** that (I) (this hospital) attended the deceased from _____, 19 67, to 2/8, 19 67, that (I) (we) last saw the deceased alive on 2/8 19 67, and that death occurred at 5:40 P.M, from causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22b. DATE SIGNED
Martin Rothstein					2/10/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
MARTIN ROTHSTEIN, MD.	48 BROADWAY, FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	FEB. 11, 1967	FROSTBURG MEMORIAL PARK	FROSTBURG, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST, SR., FROSTBURG, MD.	FEB 14 1967	Jeanes Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01609

CERTIFICATE OF DEATH

01606

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 202 Grand Ave. Cumberland 21-1
d. STREET ADDRESS: 202 Grand Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna — Middle: Mary — Last: Waters

4. DATE OF DEATH: Month: Feb. — Day: 1 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 20, 1882

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Green

14. MOTHER'S MAIDEN NAME: Margaret Clauser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Daughter — Address: Mrs. Wm. T. Dillon, Baltimore, Md.

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Brain Syndrome — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): Circulatory Disturbance — 1 week
DUE TO
(c): Hypertensive Vascular Disease — 5 years

447X

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.)

20c. TIME OF INJURY Month, Day, Year: Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 28, 19 66, to Feb. 1, 19 67 that (I) (we) last saw the deceased alive an Feb 1 19 67, and that death occurred at 9:55 PM, from causes and an the date stated abave.

22a. SIGNATURE: A Paige Strong — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Feb. 2, 1967

22c. PHYSICIAN'S NAME (Type): Dr. A. Paige Strong, M.D.

22d. ADDRESS: 167 E. Main St - Frostburg Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 4, 1967

23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

23d. LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR — DATE: FEB 7 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01610 01607

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 9 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MT. SAVAGE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle E Last WHARTON
4. DATE OF DEATH: Month 2/22/67 Day Year 19
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/11/86
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED - DYE HOUSE
10b. KIND OF BUSINESS OR INDUSTRY: CELANESE CORP.
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EDWARD WHARTON
14. MOTHER'S MAIDEN NAME: ELIZABETH ASHKETTLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 214-01-0110A
17. INFORMANT Address: PT'S CHART

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — 15 YRS
DUE TO (c): Congestive Heart Failure — 2 DAYS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized Arteriosclerosis & Osteoarthritis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): None
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 8, 19 65, to Feb 22, 19 67, that (I) (we) last saw the deceased alive on Feb 22, 19 67, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: James R. Halloran M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2-23-67
22c. PHYSICIAN'S NAME (Type): DR. HALLINAN
22d. ADDRESS: 148 Bedford St. Cumberland Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 2-24-67
23c. NAME OF CEMETERY OR CREMATORY: ST. PATRICK'S CEMETERY
23d. LOCATION (City, town or county) (State): MT. SAVAGE, MD.

24. FUNERAL DIRECTOR ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD.
25a. REC'D BY REGISTRAR DATE: FEB 27 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film G385 2/14/67 mh

CERTIFICATE OF DEATH

01611 — 01608

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town): Lonaconing 01.1
d. STREET ADDRESS: Beechwood Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SIMEON Middle W. Last WHITEMAN

4. DATE OF DEATH: Month 2/8/1967 Day Year 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/14/1898 (1897)

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired INS. Agent

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Garrett CO.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Whiteman

14. MOTHER'S MAIDEN NAME: Eliza Ellen Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes-World War # 1

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Maria Whiteman (WIFE), Lonaconing, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): ACVD + coronary art. disease — 5 years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19 60, to 2·8, 1967, that (I) (we) last saw the deceased alive on 2·8 1967, and that death occurred at 10 P M, from causes and on the date stated above.

22a. SIGNATURE: L.R. Miles

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2·9·67

22c. PHYSICIAN'S NAME (Type): L.R. MILES, JR

22d. ADDRESS: LONACONING MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/11/1967

23c. NAME OF CEMETERY OR CREMATORY: Memorial Park

23d. LOCATION (City or Town) (County) (State): Frostburg, MD.

24. FUNERAL DIRECTOR: GEORGE EICHHORN

ADDRESS: Lonaconing, Md.

25a. REC'D BY REGISTRAR DATE: FEB 10 1967

25b. REGISTRAR'S SIGNATURE: Jolanta Judy

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01612

CERTIFICATE OF DEATH

01609

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 47 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest town): CUMBERLAND
d. STREET ADDRESS: 744 FAYETTE STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle P. Last ZIMMERMAN

4. DATE OF DEATH: Month FEBRUARY Day 25 Year 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-18-1902

9. AGE (In yeors last birthday): 64 yrs.

IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Haurs / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: Beverage Salesman

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: CHARLES P. ZIMMERMAN

14. MOTHER'S MAIDEN NAME: LAURA B. KELLY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: MEMORIAL HOSPITAL-CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Squamous Carcinoma, lung, right — INTERVAL BETWEEN ONSET AND DEATH: 2 years +
DUE TO
(b): with Cerebral metastasis — 6 months
Conditions, if ony, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

163X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Haur a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 20, 1966, to Feb 25, 1967, that (I) (we) last saw the deceased alive on Feb 24 1967, and that death occurred at 1:05 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Wylie M Faw Jr
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Feb 27, 1967

22c. PHYSICIAN'S NAME (Type): DR. WYLIE M. FAW

22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/27/67

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Md.

24. FUNERAL DIRECTOR: Louis Stein Inc.

ADDRESS: 117 Frederick St.

25a. REC'D BY REGISTRAR DATE: FEB 28 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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